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DATE: October 26, 2005 BQA Memo 05-012

TO: Nursing Homes NH - 07

FROM: Jan Eakins, Chief
Provider Regulation and Quality Improvement Section

VIA: Otis Woods, Director
Bureau of Quality Assurance

UPDATE: Nursing Home Reporting Requirements For Alleged Incidents of Abuse, Neglect and Misappropriation

The Center for Medicare and Medicaid Services (CMS) Survey and Certification (S&C) Memo 05-09 at www.cms.hhs.gov/medicaid/survey-cert/sc0509.pdf, clarified mandatory reporting requirements for participating Medicare and Medicaid providers. BQA issued Memo 05-004 to all nursing homes to provide direction on how to report these alleged violations to BQA.

The purpose of this memo is to further clarify the federal and state resident mistreatment reporting requirements for all nursing homes in Wisconsin. For purposes of this memo, "mistreatment" includes any incident or allegation involving an injury of unknown source, abuse or neglect of a resident, or misappropriation of a resident's property.

This memo contains important clarification regarding:
- Nursing Home Reporting Requirements;
- Definitions under Federal and State Law;
- Reporting Forms & Tools; and
- BQA's Response to Incident Reports.

Nursing Home Reporting Requirements

REFERENCE: BQA Memo 05-004, Clarification of Nursing Home Reporting Requirements
http://dhfs.wisconsin.gov/rl_DSL/Publications/pdfmemos/05-004.pdf
Wisconsin Caregiver Program Manual, Chapter 6
http://dhfs.wisconsin.gov/caregiver/publications/CgvrProgMan.htm.

All nursing homes are required to develop **written procedures** specifying:
- What incidents are to be reported;
- How and to whom staff are to report incidents;
- How internal investigations will be completed;
- How staff will be trained on the procedures related to allegations of misconduct; and
- How residents will be informed of those procedures.

All nursing homes must ensure that employees, contractors, volunteers, and residents are knowledgeable about the nursing home's reporting procedures and requirements. Staff must be trained to **immediately**

report to the administrator or designee all incidents of misconduct, including abuse or neglect of a resident, misappropriation of a resident's property, or injuries to a resident of unknown source.

Immediately upon learning of an incident, all nursing homes must take the necessary steps to **protect residents** from possible further incidents of misconduct or injury. In addition to federal and state reporting requirements, providers are encouraged to **notify local law enforcement** authorities of any situation where there is a potential criminal offense.

All nursing homes must immediately begin a thorough **investigation** of all incidents and **document** the findings for each incident. A thorough investigation may include:

- Collecting and preserving physical and documentary evidence;
- Interviewing alleged victim(s) and witness(es);
- Interviewing accused individual(s) (includes staff, visitors, resident's relatives, etc.) allegedly responsible for mistreatment, or suspected of causing an injury of unknown source;
- Collecting other information that corroborates the report of the incident or disproves it; and
- Involving other regulatory authorities who may assist, e.g., local law enforcement, elder abuse agency, Adult Protective Service agency.

All nursing homes should take these steps as part of the initial attempt to determine what, if anything, happened, and to determine the complete factual circumstances surrounding the alleged incident. The immediate investigation will assist in determining whether an incident must be reported to BQA within 24 hours, within five working days, both, or neither. If an incident is reported to BQA, the entity's investigation becomes part of the BQA caregiver misconduct investigation.

Definitions under Federal and State Law

The attached document, entitled "Misconduct Definitions," provides a comparison of the federal and state definitions in nursing home settings.

Federal Definitions for Alleged Violations

REFERENCE: CMS S & C Memo 05-09, Clarification of Nursing Home Reporting Requirements
www.cms.hhs.gov/medicaid/survey-cert/sc0509.pdf

Participating Medicare and Medicaid nursing homes must review the federal definitions to determine whether an incident involves an alleged violation that must be reported within 24 hours. If an incident potentially meets the federal definition, it is not necessary to review the state definitions.

However, due to slight differences in federal and state definitions, some incidents may not meet the federal definitions, but may still meet the state definitions. In such instances, a DDE-2617 is not required within 24 hours, but the provider must still follow the Caregiver Law reporting requirements. This may most likely occur in cases of neglect.

Caregiver Misconduct Definitions

REFERENCES: Wisconsin Caregiver Program Manual, Chapter 6
http://dhfs.wisconsin.gov/caregiver/publications/CgvrProgMan.htm
Chapter HFS 13, Wisconsin Administrative Code
http://dhfs.wisconsin.gov/caregiver/StatutesINDEX.HTM

Refer to Chapter 6 of the Manual for case examples and investigation strategies.

Examples: Incidents that may or may not need to be reported based on Federal & State definitions.

- A nurse aide pushes a resident onto the toilet to change the resident's pants and sits on the resident when she tries to stand up. This incident meets the federal definition of abuse, because the nurse aide intentionally and unreasonably confined the resident. A DDE-2617 is required. This incident also meets the state definition of neglect, because the nurse aide engaged in an intentional course of conduct which was not part of the resident's care plan, could cause injury, and disregarded the resident's rights to be treated with respect and dignity. After the entity completes the investigation, it must submit a DDE-2447.

- A nurse aide places her hands on a resident's shoulders to hold the resident on the toilet to change his pants, preventing him from standing up. This incident may not meet the federal or state definition of abuse, because the aide did not intend to harm the resident, nor did she unreasonably confine him, unlike the example above. In addition, it may not meet the federal definition of neglect, because the nurse aide did not fail to provide goods or services. No DDE-2617 is required. However, it may meet the state definition of neglect if the aide knowingly did not follow the resident's care plan (if, for example, the care plan required that the aide re-approach the resident when he resists dressing). Therefore, after the entity completes the investigation, it may be necessary to submit a DDE-2447.

Reporting Forms

Reporting Decision Tools

The following tools are available for all nursing homes to use to determine whether an incident is reportable to BQA:

- Caregiver Misconduct Reporting Requirements Worksheet
  http://dhfs.wisconsin.gov/rl_DSL/Publications/pdfmemos/04-028wksht.pdf
- Flowchart for Investigating and Reporting Caregiver Misconduct or Injuries of Unknown Source
  http://dhfs.wisconsin.gov/rl_DSL/Publications/pdfmemos/04-028flow.pdf

These reporting decision tools are based on Wisconsin's Caregiver Law reporting requirements so participating Medicare and Medicaid nursing homes must adjust the use of these tools to apply during the first 24 hours after discovery of an incident and refer to the federal definitions of abuse, neglect, misappropriation, and injury of unknown source.

Participating Medicare and Medicaid nursing homes have **24 hours from the date of discovery** of an incident to report all alleged violations involving mistreatment (including abuse, neglect, injuries of unknown source, and misappropriation of property). If during this 24 hour period, the nursing home determines that the information presented does not constitute a violation, it does not have to be reported to BQA.

Examples: Incidents that do not have to be reported to BQA.

- A resident's unexplained skin tear is reported to the Administrator. Upon review within the first 24 hours of discovery, it is determined that the resident pinched her hand when self-ambulating in her wheelchair. Therefore, the incident is not considered an allegation of an injury of unknown source as defined. You must document your investigation and decision, but it is not necessary to report the incident to BQA.

- A resident's wallet is discovered missing. Within the first 24 hours of discovery, the wallet is found in the laundry and no items are missing. Therefore, it is not considered an allegation of misappropriation as defined. You must document your investigation and decision, but it is not necessary to report the incident to BQA.

Conversely, if an incident potentially meets the federal definition, and the nursing home does not conclusively determine otherwise within the 24 hours from discovery, a participating Medicare and Medicaid nursing home must submit the DDE-2617.

Alleged Nursing Home Resident Mistreatment Report (DDE-2617)
REFERENCE: http://dhfs.wisconsin.gov/forms/DDES/DDE2617.pdf

If you conclude that you must report the incident to BQA within 24 hours based on federal definitions, complete the *Alleged Nursing Home Resident Mistreatment, Neglect and Abuse Report* form, DDE-2617, as follows:

- Indicate when the incident occurred. Include the month, date, year, and time of the incident (for example, 08/25/2003, 10:30 AM). If you do not know the exact date, provide an approximate date, such as the week of March 1, or the month of March, or between March 1 and April 15. If you give approximate dates, explain how you determined the dates.

- Briefly describe the incident including who was involved, what occurred, and where it occurred. For example, "Nurse B found resident A on the floor of A's room with a large bruise above his left eye," or "Nurse aide C transferred resident A without a gait belt resulting in the resident falling and sustaining a skin tear on his right knee."

- E-mail the DDE-2617 to Caregiver_Intake@dhfs.state.wi.us or fax it to 608-243-2020. It is not necessary to send additional documentation with the DDE-2617. Additional documentation should be sent with the DDE-2447.

For every DDE-2617 submitted, a DDE-2447 detailing the investigation MUST be submitted within five working days. If, based on your investigation, you conclude that the incident does not meet the definition or did not occur, you must still provide the information that led you to that conclusion on the DDE-2447 and submit that report to BQA.

Caregiver Misconduct Incident Report (DDE-2447)
REFERENCES: Wisconsin Caregiver Program Manual, Chapter 6
http://dhfs.wisconsin.gov/caregiver/publications/CgvrProgMan.htm
DDE-2447 (Rev. 10/04)
http://dhfs.wisconsin.gov/forms/DDES/DDE2447.pdf

You must complete the *Incident Report of Caregiver Misconduct* form, DDE-2447 when:

- You submitted a DDE-2617 within 24 hours of an incident; or

- You concluded that an incident did not meet federal definitions so you did not submit a DDE-2617 but upon further review, the incident does meet state definitions; or

- You are a state-only licensed nursing home (not a participating Medicare and Medicaid provider). The federal reporting requirements do not apply to state-only licensed nursing homes, which may continue to follow the requirements in BQA Memo 04-028.

Follow these steps to report the results of an investigation to BQA:
1. Thoroughly complete the *Incident Report of Caregiver Misconduct* form (DDE-2447), and attach relevant investigation documents (including a copy of the DDE-2617, if previously submitted).
2. Ensure the completed Incident Report is submitted within five (5) working days of the incident, or the date the entity became aware of the incident.
3. Submit all Incident Reports to:

Bureau of Quality Assurance
Office of Caregiver Quality
2917 International Lane, Suite 300
Madison, WI 53704

All reports are submitted to the Office of Caregiver Quality (OCQ). OCQ will forward reports involving:
- Facility issues (resident to resident abuse, policy and procedure issues, etc.) to the appropriate BQA Resident Care Review Section (RCRS) Regional Office; and
- Credentialed staff (Physicians, RNs, LPNs, Social Workers, etc.) to the Department of Regulation & Licensing (DRL).

BQA's Response to Incident Reports

REFERENCE: Wisconsin Caregiver Program Manual, Chapter 6
http://dhfs.wisconsin.gov/caregiver/publications/CgvrProgMan.htm

BQA responds to two types of health care complaints:
1. Complaints regarding entity activity (inappropriate or inadequate activity by an entity).
2. Complaints of caregiver misconduct (inappropriate activity by individual caregivers).

When BQA receives a complaint of caregiver misconduct from an entity or another source, the report is screened by BQA's Office of Caregiver Quality (OCQ) to determine whether further investigation is warranted. Investigation screening decisions are made on a case-by-case basis. OCQ notifies the accused person, entity, staffing agency (if applicable), and complainant by letter whether an investigation will be conducted by OCQ. OCQ may conduct a caregiver misconduct investigation by conducting on-site visits, in-person interviews, or telephone interviews. Caregiver misconduct investigations are completed either by state investigators or contracted private investigators. Not all reported incidents are investigated by OCQ. However, OCQ does track and monitor all incident reports. When OCQ observes a pattern of reported incidents involving a caregiver, an investigation may be opened at a later date.

In order for the Department of Health and Family Services (DHFS) to substantiate a finding of misconduct against a caregiver, the incident must meet the state definition of caregiver abuse, neglect, or misappropriation. After completing a caregiver misconduct investigation, OCQ determines whether there is sufficient evidence to substantiate the complaint. An incident may violate the work rules or procedures of a facility, but at the same time, not meet the definitions or the evidentiary standards of HFS ch. 13. Therefore, it is possible an employer may appropriately discipline or terminate a caregiver for a particular incident, but OCQ may determine the incident does not constitute caregiver misconduct.

The Office of Caregiver Quality shares all incident reports with the BQA Resident Care Review Section (RCRS) Regional Office. The RCRS Regional Office survey staff may also conduct a parallel investigation of the incident to determine if the entity's program requirements were met and if the entity bears culpability for the incident.

Questions

Contact the Office of Caregiver Quality at **Caregiver_Intake@dhfs.state.wi.us** or (608) 243-2019.

Reporting Requirements Summary
Train all staff to **immediately report to the administrator or designee** all incidents of misconduct, including abuse, neglect, injuries of unknown source, or misappropriation of a resident's property.

ACTION	Requirements under **federal regulations** and **state law** for **nursing homes** that: • are licensed in Wisconsin, **and** • **participate** as Medicare and Medicaid providers [§483.13]	Requirements under **state law** for all other **BQA regulated entities** (including Nursing Homes that: • are licensed in Wisconsin, **and** • do not participate as Medicare or Medicaid providers) [Ch. HFS 13]
STEP 1: Protect the resident(s) from harm	Immediately upon learning of an incident of client mistreatment or discovering an injury of unknown source, the entity must take the necessary steps to **protect all residents** from possible subsequent incidents of mistreatment or injury.	
STEP 2: Respond and Report	**Within 24 hours**, incidents of mistreatment or injuries of unknown source must be reported to the nursing home administrator (or his or her designee), the state survey and certification agency (BQA/OCQ), and other officials, as required by state law and established procedure. • Use reporting form **DDE-2617** • E-mail the DDE-2617 to **Caregiver_Intake@dhfs.state.wi.us** or fax it to 608-243-2020.	Upon learning of an injury or incident of misconduct, the entity must determine whether the incident was the result of a caregiver's misconduct. To make this determination, the entity must conduct an initial investigation into the matter, including obtaining the information requested on the Incident Report form, DDE-2447. If the entity determines that the conduct does constitute caregiver misconduct or may constitute caregiver misconduct with further investigation, the entity must report the incident and the results of the investigation to BQA/OCQ **within five working days (nursing homes & FDDs) or seven calendar days (all other BQA regulated entities)**. • Use reporting form **DDE-2447** and submit to: *Bureau of Quality Assurance* *Office of Caregiver Quality* *2917 International Lane, Suite 300* *Madison, WI 53704*
STEP 3: Conduct and Document a thorough investigation	Each nursing home must have evidence that all alleged violations involving client mistreatment or injuries of unknown source are thoroughly investigated. For every DDE-2617 submitted, a DDE-2447 detailing the investigation must be submitted.	
STEP 4: Report the results of the investigation	**Within five working days,** the nursing home must report the results of the investigation to the nursing home administrator (or his or her designee), to the state survey and certification agency (BQA/OCQ) and other officials in accordance with state law. • Use reporting form **DDE-2447** and submit to: *Bureau of Quality Assurance* *Office of Caregiver Quality* *2917 International Lane, Suite 300* *Madison, WI 53704*	

<table>
<tr><td></td><td colspan="2">In addition to referring to the “Misconduct Definitions” for guidance on whether the conduct is reportable under federal or state law, all entities can use these tools to determine if an incident is reportable to BQA:
• Caregiver Misconduct Reporting Requirements Worksheet http://dhfs.wisconsin.gov/rl_DSL/Publications/pdfmemos/04-028wksht.pdf, and
• Flowchart for Investigating & Reporting Caregiver Misconduct or Injuries of Unknown Source http://dhfs.wisconsin.gov/rl_DSL/Public ations/pdfmemos/04-028flow.pdf.</td></tr>
<tr><td rowspan="2">STEP 5:
Corrective action</td><td>If the alleged violation is verified, appropriate corrective action must be taken.</td><td></td></tr>
<tr><td colspan="2">Note: If the individual implicated in the alleged conduct was a family member, visitor or another client, the entity must document that it has taken appropriate steps to respond to the incident and to address the conduct or behavior to prevent harm or injury to other clients.</td></tr>
<tr><td rowspan="2">STEP 6:
Notify the accused individual</td><td colspan="2">An entity must notify the caregiver that an allegation of abuse, neglect, or misappropriation of property has been made and that the report has been forwarded to the appropriate authority.</td></tr>
<tr><td>If the State makes a preliminary determination, based on oral and written information and its investigation, that abuse or neglect of a client or misappropriation of a client’s property occurred, it must notify the individual/caregiver implicated in the investigation and the nursing home administrator of the facility in which the incident occurred within ten working days of the State’s investigation.</td><td>If, after reviewing the information submitted by the entity, the State makes a preliminary determination, that further investigation is necessary, it must provide notice of its investigation to the accused caregiver.

If, after completing its investigation, the State determines that abuse or neglect of a client or misappropriation of a client’s property occurred, it must promptly notify the accused caregiver and the administrator of the entity in which the incident occurred.</td></tr>
<tr><td>STEP 7:
Appeal

Hearing

Decision</td><td colspan="2">The individual/caregiver must be advised that failure to request a hearing in writing within 30 days from the date of the notice will result in reporting the substantiated finding to the Wisconsin Caregiver Misconduct Registry, or appropriate licensing authority.

The hearing must be held within 90 days from the day the request for the hearing is filed.

A written decision must be issued within 30 calendar days after the conclusion of the hearing. The decision must advise the caregiver of the right to file a rebuttal statement. Copies of the decision are provided to the subject, the Department, the reporter, and the entity involved in the alleged incident.</td></tr>
<tr><td>STEP 8:
Reporting the finding</td><td colspan="2">If the finding is that the individual/caregiver abused or neglected a client, or misappropriated a client’s property, or if the individual waived the right to a hearing, the finding must be reported within ten working days to the individual/caregiver; the administrator of the nursing home where the incident occurred; the licensing authority for individuals/caregivers used by the facility other than nurse aides, if applicable; and the Caregiver Misconduct Registry.</td></tr>
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Attachment: Misconduct Definitions (2005)